Wichita Employees' Retirement System

Declaration of Group Health Insurance

I. As a **DEFERRED RETIREE** from the City of Wichita, Wichita Employees' Retirement System, I hereby elect to continue as a member under the City's **GROUP HEALTH INSURANCE**.

☐ I understand that the City's Group Health Insurance coverage is only available until I reach 65 years of age (100% premium to age 60, then 75% premium to age 65). My spouse, if younger and I have family coverage, may continue until 65 years of age at 100% of the premium.

☐ I further understand that if I fail to have the monthly premium payment in the Pension Management Office by the 20th of the month prior to the coverage month, my insurance may be canceled. If canceled, I am not eligible to re-enroll in the group.

☐ I understand that no premium notices or reminders will be sent.

I desire the following coverage: ☐ Family ☐ Single

_____ _____

Retiree's Signature Date Birth Date

II. As a **DEFERRED RETIREE** from the City of Wichita, Wichita Employees' Retirement System, I hereby elect **NOT** to continue as a member under the City's **GROUP HEALTH INSURANCE PROGRAM.** I wish to cancel my coverage under the Health Insurance Program effective _____ .

_____ _____

Retirees' Signature Date Birth Date

Return this form to:

Pension Management
455 N Main, 12th Floor
Wichita, KS 67202
(316) 268-4549